

Date: [Insert Date]

To: [Receiving Therapist/Provider Name]

Facility: [Receiving Facility Name]

Fax/Email: [Insert Contact Info]

RE: Patient Transfer of Care

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Diagnosis/ICD-10: [Primary Diagnosis, e.g., Post-Op ACL Reconstruction]

Date of Injury/Surgery: [Insert Date]

Dear [Recipient Name],

This letter is to formally transfer the orthopedic physical therapy care of the above-named patient to your facility due to [Reason for Transfer, e.g., patient relocation/insurance change].

Current Clinical Status:

The patient has completed [Number] sessions at our facility. Current progress includes [Brief Summary of ROM, Strength, and Functional Status]. The patient is currently adhering to [Name of Surgeon]'s protocol for [Specific Procedure].

Current Goals:

- [Goal 1, e.g., Restore full terminal knee extension]
- [Goal 2, e.g., Progress to plyometric loading phase]
- [Goal 3, e.g., Achieve 5/5 strength on MMT for hip abductors]

Precautions/Contraindications:

[List any weight-bearing restrictions, ROM limits, or specific movement contraindications].

Recommended Plan of Care:

We recommend continued therapy at a frequency of [Number] sessions per week for [Number] weeks, focusing on [Specific Focus, e.g., sport-specific agility and eccentric strengthening].

Attached you will find the initial evaluation, most recent progress note, and surgical protocol. Please contact our office at [Your Phone Number] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name, PT/DPT]

[Your Facility Name]